



MD BOARD OF OCCUPATIONAL THERAPY PRACTICE

Spring Grove Hospital Center • 55 Wade Avenue • Bland Bryant Building

4th Floor • Baltimore, MD 21228

Phone: 410-402-8560 • Fax: 410-402-8561 • Website: <http://dhmh.maryland.gov/botp>

MORAL CHARACTER ENDORSEMENT FORM

I. To Be Completed By Applicant:

Name of Applicant: _____ Social Security Number: XXX - XX - _____

Address: _____ Email : _____

City/State/Zip: _____ Phone (____) _____

License Type You Are Applying For:

Official License:	<input type="checkbox"/> OT	<input type="checkbox"/> OTA
Temporary License:	<input type="checkbox"/> OT	<input type="checkbox"/> OTA
Reinstatement:	<input type="checkbox"/> OT	<input type="checkbox"/> OTA
Reactivation:	<input type="checkbox"/> OT	<input type="checkbox"/> OTA

II. To Be Completed By Moral Character Reference:

The Maryland State Board of Occupational Therapy Practice is gathering information to determine whether the applicant for licensure to practice occupational therapy in Maryland can be anticipated to do so ethically. **Persons who complete this form must have observed the applicant's clinical skills, and not be related to the applicant.**

To the best of your knowledge, has the applicant:

Must check Yes or No

- | | |
|---|---|
| 1. Complied with all applicable laws dealing with the practice of occupational therapy? | 1. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Appropriately represented his or her skills? | 2. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Provided only those procedures, which appeared to be safe for the client? | 3. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Provided appropriate services to clients without discrimination based on age, race, creed, national origin, sex, sexual orientation, handicap, or religious affiliation? | 4. <input type="checkbox"/> YES <input type="checkbox"/> NO |

CONTINUED ON BACK

TDD FOR DISABLED
MARYLAND RELAY SERVICE
1-800-735-2258

Reminder:

If this form has been completed by someone who has not observed the applicant's clinical skills, it will be rejected and may delay the processing of this application.

Must check Yes or No

- | | |
|---|---|
| 1. Shown respect for clients' rights, including the right to refuse treatment? | 5. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. Avoided cruel, inhumane, or degrading practices in the treatment of clients? | 6. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 7. Provided quality services to clients? | 7. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 8. Placed the needs of the client above personal gains, financial or otherwise? | 8. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 9. To the best of my knowledge, the applicant is of good moral character. | 9. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 10. How long have you been acquainted with the applicant? | 10. _____ Months
_____ Years |

11. Describe the manner in which you are familiar with the applicant's clinical skills.

12. I attest that the information provided is true to the best of my knowledge:

Name

Signature

Job Title

Date

Professional Email Address

Address

City/State/Zip

(_____) _____
Home Phone number

(_____) _____
Work Phone Number

DO NOT FORWARD THE COMPLETED FORM TO THE APPLICANT. You may be contacted by the Board for verification. The completed form must be returned via:

1) US Mail:

MD Board of Occupational Therapy • Spring Grove Hospital Center • 55 Wade Avenue • Bland Bryant Building, 4th Floor • Baltimore, MD 21228

2) Email: mboard.user@maryland.gov ; or **3) Fax:** (410) 402-8561